STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING _____ B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE OF INDIAN/	8350 S EMERSON AVE #140 INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for a state hospice complaint investigation. Complaint #IN00104118 - Unsubstantiated: Lack of sufficient evidence IN00098857- Substantiated: No deficiencies related to the allegation are cited. Survey Date: 04/04/12 Facility # 011779 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Medicaid # 200920020 Seasons Hospice and Palliative Care of Indiana, LLC is in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.54, 418.56, and 418.64 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN April 9, 2012	S 000		